





The Impossibility of
Working in the Current
NHS.

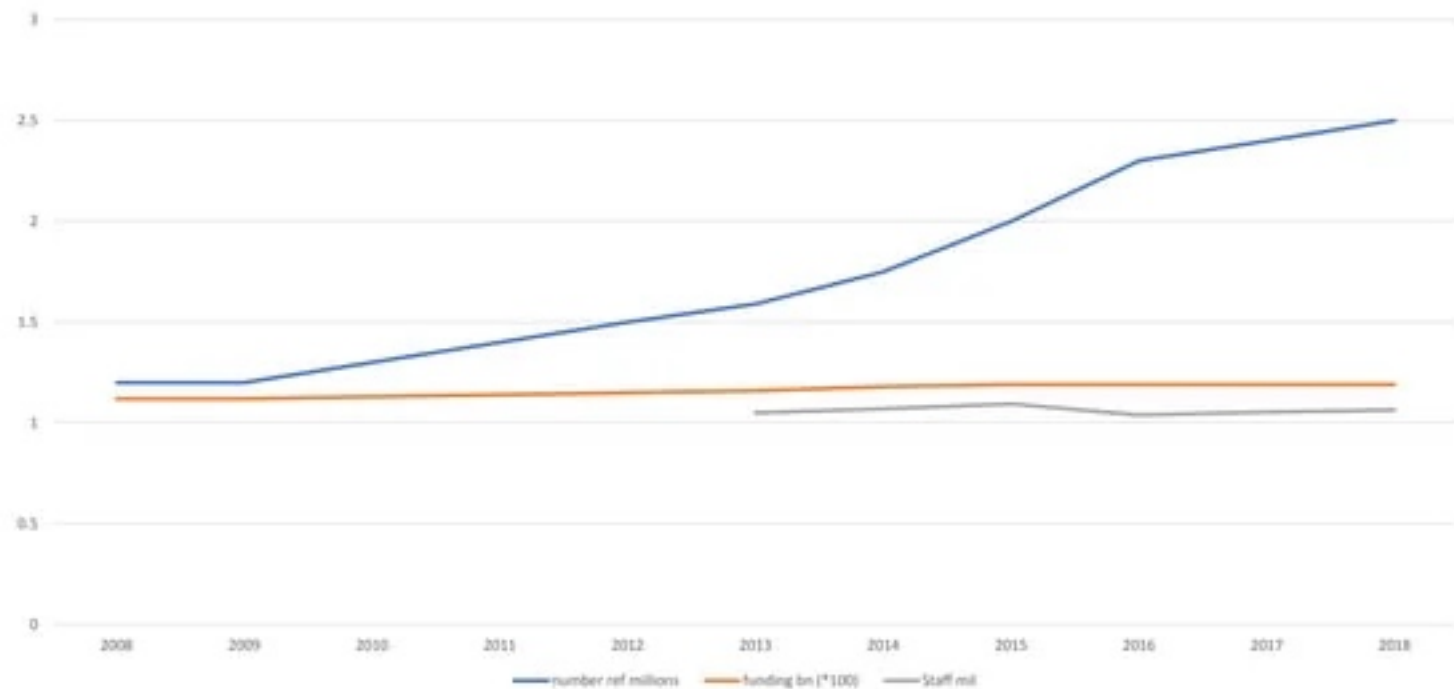
*Sacrifice to a Primitive
God*

Dr Rachel Gibbons. Consultant Psychiatrist,
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Tasks

- Conscious task to reduce anxiety about survival in traumatised society
- Unconscious task: Meet the dependency needs of staff and society resulting from trauma

NHS Resource problem



2007: This is Going to Hurt by Adam Kaye.

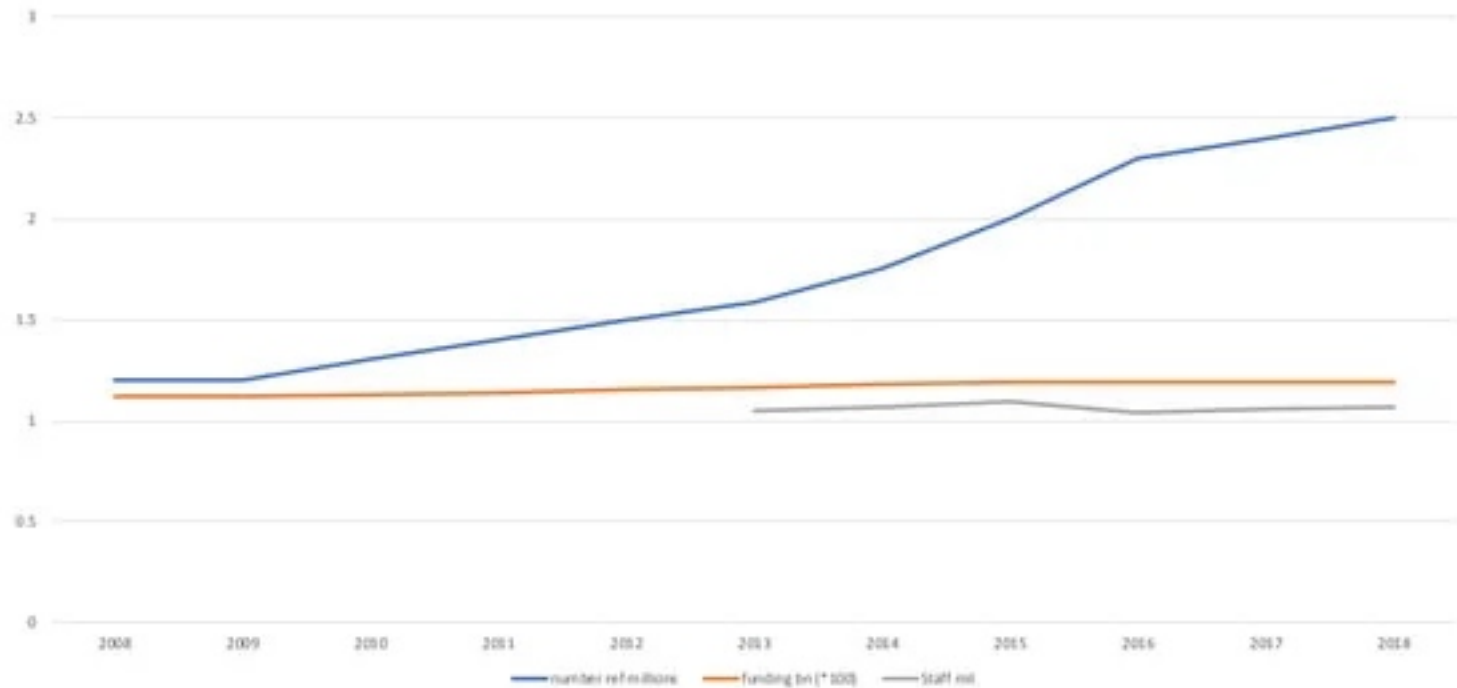
During the day, the job was manageable, if mind-numbing... Essentially, you're a glorified PA. Not really what I'd trained so hard for, but whatever. The night shifts, on the other hand, made Dante look like Disney – an unrelenting nightmare that made me regret ever thinking my education was being underutilized. At night, the house officer is given a little paging device affectionately called a bleep and responsibility for every patient in the hospital. The fucking lot of them. The night-time SHO and registrar will be down in A&E reviewing and admitting patients while you're up on the wards, sailing the ship alone. A ship that's enormous, and on fire, and that no one has really taught you how to sail.

You're bleeped by ward after ward, nurse after nurse with emergency after emergency – it never stops, all night long. ..You're a one-man, mobile, essentially untrained A&E department, getting drenched in bodily fluids (not even the fun kind), reviewing an endless stream of worryingly sick patients who, twelve hours earlier, had an entire team of doctors caring for them. It's sink or swim, and you have to learn how to swim because otherwise a ton of patients sink with you. I actually found it all perversely exhilarating. Sure, it was hard work, sure the hours were bordering on inhumane and sure I saw things that have scarred my retinas to this day, but I was a doctor now.

I must get what I need now!

- Dependent Personality disorder
- No boundaries allowed
 - Emails
 - Waiting times
 - Personal Resources
 - Referrals

NHS Resource problem





Jack Adcock's death

On 18 February 2011, Jack Adcock, a 6 year old boy, was referred to Leicester Royal Infirmary by his [GP](#) and admitted to a Children's Assessment Unit (CAU) at 10.20am. He had [Down's syndrome](#) and had a [atrioventricular septal defect](#) repaired at 4.5 months of age. He was on an [angiotensin converting enzyme inhibitor, enalapril](#). He presented with diarrhoea, vomiting and difficulty breathing.[\[1\]](#)

He was treated by Dr Bawa-Garba, an ST5 [Specialty registrar](#) (paediatrics) who was on her first day back from maternity leave. She had not received any formal induction or training for her new job. Bawa-Garba was alone in charge of the [paediatric emergency department](#) and Children's Assessment Unit on the day, with no senior consultant available. Rota gaps had meant that Bawa-Garba had to cover the work of two other doctors[\[9\]](#) and the on-call consultant was off-site in [Warwick](#) until 4.30 pm that day, as he had not realised he was on-call. The morning hand-over between the incoming and outgoing teams was not completed due to a cardiac arrest call.

Soon after admission, Bawa-Garba was alerted to Jack's condition by the nursing staff in CAU. After clinical examination, she found him to be dehydrated. A [point-of-care](#) venous blood gas revealed profound [Metabolic acidosis](#) with a lactate of 11.4mmol/L and serum pH of 7.084. She diagnosed hypovolaemia from gastroenteritis, and administered [Fluid replacement](#). Blood tests were sent off for laboratory analysis and a chest x-ray was requested.

Bawa-Garba made a number of mistakes. She did not ask the on-call consultant to review Jack during an afternoon handover meeting at 4.30pm but did share abnormal laboratory results with him which he duly wrote down in his notebook. However, the consultant did not review the patient as he expected Bawa-Garba to "stress" these results to him. It was the first occasion they were working on the same shift. Although she deliberately omitted the patient's medicine enalapril on the drug chart she did not make it clear to the child's mother not to give it. Jack's mother subsequently gave it to the child that day at 7pm which led to the child's circulatory shock and death.[\[10\]](#) This was the custom and practice in the hospital - to permit parents to administer medicines in the hospital before being prescribed.

Mental health staff on long-term stress leave up 22%

By George Greenwood BBC News Feb 19

Health service is chaotic and dysfunctional, says NHS chief Lord Prior of Brampton

February 15 2019, 12:01am, The Times

NHS staff survey reveals a workforce in crisis says BMA

BMA: 27 February 2019

Experts warn shortage of GPs will last for at least a decade

Chris Smyth March 21 2019, The Times

Think tank report March 19:

Fifty per cent more NHS staff now report debilitating levels of work stress compared to the general working population, and year after year, around 40 per cent report being unwell as a result of work stress during the previous year.

King's College hospital trust makes biggest overspend in NHS history. April 19

A leading [London](#) hospital trust is expected to record an annual deficit of between £180m and £191m – the biggest overspend in NHS history, the Guardian can reveal.

The trust is struggling with the most serious financial problems in the NHS as a result of a private finance initiative (PFI) contract, high use of agency staff to cover its chronic lack of nurses, and being fined for missing the [four-hour A&E target](#).

- "Use every man according to his desert and who shall 'scape whipping?" Hamlet

